minimize the possibility of rheumatic fever. Clinical accuracy in the previously mentioned series was approximately 70 percent for adults and 40 percent for children. This is high enough to justify immediate therapy without culture for adults, provided it is oral and the danger of anaphylaxis is avoided.

Penicillin injections in children are not justified because of the inaccuracy of clinical diagnosis and the danger of delayed sensitivity in later life. However, the greater incidence of rheumatic fever in children suggests that oral therapy should be started pending culture. Studies have shown that eradication of steptococcal infection is excellent by oral therapy if proper instruction is given to the patient.

By following these criteria, over 70 percent of cultures can be eliminated. A majority of clinicians already treat on the basis of clinical judgment. By adhering to standard criteria and taking cultures in pediatric pharyngitis and questionable cases in adults, the cost of medical care can be reduced without danger.

ROGER A. FORSYTH, MD

REFERENCES

Forsyth RA: The rationale of treatment of pharyngitis on the basis of clinical diagnosis. To be published

Colcher IS, Bass JW: Pencillin treatment of streptoccal pharyngitis. JAMA 222:657, 1972

Pain in Viral vs. Bacterial Pharyngitis

IT IS GENERALLY ACCEPTED that streptococcal pharyngitis cannot be diagnosed from clinical findings alone without significant error.

Since the two commonest bacterial organisms responsible for acute pharyngitis are the group A streptococcus and C. diphtheriae, and since the latter can usually be excluded on clinical grounds, the physician must ask, when he makes the diagnosis of pharyngitis, whether it is caused by group A streptococcus or by a virus. The diagnosis of pharyngitis is often made on the basis of the complaint of "sore throat" without definite signs of redness, exudate or ulceration of the pharynx.

In any general practice the problem of differentiating viral from bacterial pharyngitis is a daily problem. Much has been made of the "beefy" pharyngitis so often typical of streptococcal sore throat, but another aid to differentiation can be made from the history.

As a general rule, pharyngeal pain which occurs primarily or is most severe at bedtime and on arising may help to differentiate viral from bacterial sore throat. The latter tends to be more or less constant throughout the patient's waking hours. With a history of persistent daytime pharyngeal soreness, it is desirable to obtain a throat culture, even though the pharynx is not inflamed. In these patients an occasional unexpected hemolytic streptococcus infection will be discovered.

S. CLARKE SMITH, MD

REFERENCES

Rapkin RH, Eppley ML: The recognition of streptococcal pharyngitis. Community Health 10-12:706-710, Dec 1971

Schultz I, Fundelfiner B, Rosenbaum M: Comparison of clinical manifestations of respiratory illness due to Asian strain influenza, adenovirus, and unknown cause. J Lab Clin Med 55:497, 1960

Office Dilatation and Curettage

ALTHOUGH METHODS of endometrial sampling have been present for approximately fifty years, there has been relatively little acceptance of any but the traditional dilatation and curettage. Adequate diagnostic D & C can be done in the office with the Poyas cannula. The equipment needed consists of three cervical dilators and matching cannula curettes, tubing with a specimen trap, and low pressure suction pump commonly used in most offices. The stainless steel cannula curettes are 12 inches long, with a 4, 5, or 6 mm outside diameter. The tips are straightened to produce the effect of a sharp curette and the shaft is slightly curved to allow free rotation and contact with the uterine wall.

The procedure is carried out much as the traditional D & C, with a careful bimanual examination beforehand to determine uterine size, shape and position. Visualization can be improved with a weighted speculum. The cervix is then grasped with a single tooth tenaculum and cleansed. Depth is determined with the introduction of the 4 mm dilator and most cervical canals can then be dilated to the large (6 mm) diameter. If the dilatation is uncomfortable for the patient, a paracervical block using 5 cc of 1 percent lidocaine (Xylocaine®) at the 4 and 8 o'clock positions will afford adequate relief. Thorough curettage can then be carried out, and the removed tissue aspirated into the trap. The tubing can be cleared at the end of the procedure with a small amount of formalin and the specimen sent to the laboratory. Even very scanty specimens will be adequate for pathological diagnosis if a "cell block" is asked for.

Where this suction procedure has been done and the conventional method and/or hysterectomy

carried out later, it has been found there is little, if any, endometrial tissue remaining. Most small polyps will be removed and larger ones can be felt. The cannula curette thus offers a diagnostic office procedure which relieves the patient of the risk and cost of hospitalization for a traditional D & C under general anesthesia.

S. CLARKE SMITH, MD

REFERENCES

Poyas JL: Cannula curettes for office diagnostic D & C. Obstet Gynecol 38-5:783-785, Nov 1971

Hofmeister FJ: Endometrial sampling. J Reprod Med 4:33-36, 1970

Cryocautery in the Office Treatment of Chronic Cervicitis

A SIMPLE AND EFFECTIVE office technique for managing chronic cervicitis or cervical erosion—conditions which often are accompanied by a mild but chronic vaginal discharge that is not abated by treatment with various vaginal creams over a long time, with many office visits.

After a Papanicolau smear has been obtained and found to be normal, the patient is ready for definitive treatment with cryocautery. Generally, no premedication is necessary but relaxation with 10 mg of diazepam (Valium®) and 0.5 mg of atropine to control parasympathetic response is recommended by some observers. The cryocautery is applied to the cervix for 2 to 3 minutes when Freon® or carbon dioxide is the cooling agent. The margin of freezing can be visualized and is usually carried 2 or 3 mm beyond the area of the erosion. Some patients may feel some discomfort at the time of the procedure and for up to three days afterward. The discomfort is described as similar to menstrual cramps and is sometimes accompanied by light-headedness.

Following cryocauterization there is a clear, watery discharge for nearly two weeks, followed by a mucoid secretion. Intercourse is not advised for two weeks. Some patients have spotting. At the end of six weeks, the cervix is usually healed. The procedure apparently does not cause cervical stenosis that might have adverse effect on subsequent pregnancy. Some observers have reported that dysplasia of the cervix has disappeared following cryocautery treatment.

JOHN F. BRIDGEMAN, MD

REFERENCES

Townsend DE, Ostergard DR, Lickrish GM: Cryosurgery for benign disease of the cervix. J Obstet Gynecol Br Commonw 78: 667-670, Jul 1971

Kaufman RH, Conner JS: Cryosurgical treatment of cervical dysplasia. Am J Obstet Gynecol 109:1167-1173, Apr 15, 1971

Minor Tranquilizers—How Minor Are They?

IN THE MID-1950s the alkaloids of rauwolfia serpentina were introduced into this country. They had been used for centuries in the Far East. Their sedative action was characterized as tranquilization. This label has since been applied to a wide variety of other compounds with sedative effects. Each is introduced with some enthusiastic reports of clinical trials and some well-financed sales-promotion propaganda. Objective evidence of selective "transquilization" as against sedation has been almost nonexistent. By 1960 it was evident that reserpine could produce profound depression and a substantial number of suicides were attributed to its use either as a tranquilizer or in the treatment of hypertension.

Meprobamate appeared next on the scene and was hailed as an effective treatment for anxiety, safe and free from side effects. Its profound hypnotic effects were largely ignored or played down. Habituation to meprobamate was soon reported and, more startling, seizures, often fatal, were reported upon withdrawal of meprobamate from addicted persons. Again depression was a common side effect. Widely heralded muscle-relaxant properties have found little application.

The chlordiazepoxide compounds, with chlordiazepoxide (Librium®) as the first entrant, boomed to the top of the sales list in the 1960s. With this class of "tranquilizers" it was possible to demonstrate in experimental animals some difference in behavioral effects between the benzodiazepine compounds on the one hand and meprobamate and barbiturate on the other. Both chlordiazepoxide (Librium®) and diazepam (Valium®) are capable of abolishing spastic rigidity in decerebrate cats. Diazepam (Valium®) is more potent as a muscle-relaxant than Librium®. Intramuscularly administered diazepam has gained acceptance as a treatment of status epilepticus.

Physical dependence on chlordiazepoxide or diazepam resembles that seen with barbiturates and meprobamate. Patients receiving large doses for several months have experienced withdrawal symptoms within a few days. Two of ten patients had seizures a week after discontinuance; other symptoms following withdrawal were depression, agitation, insomnia, loss of appetite and aggravation of the preexisting psychopathological state.

Patients are very resistant to withdrawal of "minor tranquilizers" even though the physician